Department of HUMAN SERVICES

HCBS Habilitation Workgroup Update

LeAnn Moskowitz
LTSS Policy Specialist
DHS, IME, BMLTSS

August 17, 2020

HCBS Habilitation Workgroup Goals

The goals of the workgroup include:

- the identification of a functional assessment tool for 1915(i) HCBS Habilitation program needs-based eligibility determination that derives an acuity score,
- reviewing and amending the risk based and needs based criteria for 1915(i) HCBS Habilitation program eligibility to more clearly define the eligible population,
- reviewing the Home-Based Habilitation Tiers to align with the newly identified functional assessment tool acuity scoring,
- amending the 1915(i) State Plan Amendment (SPA),
- reviewing and amending the Habilitation administrative rules to align with SPA,
- adding the Individual and Placement and Support (IPS) Supported Employment Evidenced Based Practice Model
- developing a unified training presentation targeted at Habilitation providers and Integrated Health Home (IHH) Care Coordinators and Community-based Case Managers to assist with implementation of the changes to the Habilitation Program

Assessment Tools Under Review

- The Adult Needs and Strengths Assessment (ANSA)
- The Level of Care Utilization Scale (LOCUS)
- The Daily Living Activities-20 (DLA-20)

Implementation Target Dates

- The goal is to have the draft SPA and admin rules out for public comment and tribal notice by September 30, 2020
- The goal is to have a CMS approved SPA and adopted Administrative Rules implemented January 1, 2021

Department of HUMAN SERVICES

Health Home Learning Collaborative

interRAI
Community Mental Health (CMH) Assessment & Children and Youth Mental Health (ChYMH) Assessment

July 17, 2020

This training is a collaborative effort between the Managed Care Organizations and Iowa Medicaid Enterprise

Iowa Medicaid Enterprise
Pamela Lester
plester@dhs.state.ia.us
LeAnn Moskowitz
lmoskow@dhs.state.ia.us

Amerigroup
Sara Hackbart
sara.hackbart@amerigroup.com
David Klinkenborg
david.klinkenborg@amerigroup.com
Emma Badgley
emma.badgley@amerigroup.com

Iowa Total Care
Bill Ocker
Bill.J.Ocker@IowaTotalCare.com
Tori Reicherts
Tori.Reicherts@IowaTotalCare.com

AGENDA

1. Introductions
2. Habilitation Workgroup Update…….LeAnn Moskowitz, IME
3. *interRAI Community Mental Health (CMH) Assessment & Children and Youth Mental Health (ChYMH) Assessment*…….. Emma Badgley AGP
4. Health Home Case Study or Health Home Spotlight……Health Home
5. Open Discussion……..…All

Coming up:

- *September 21, 2019 Person Centered Philosophy*
- *October 14, 2020 Virtual Event*
- *November 16, 2020 2021 Performance Measures*

Logistics

- Mute your line
- Do not put us on hold
- We expect attendance and engagement.
- Type questions in the chat as you think of them, we will address them at the end.

Health Home Updates

- Enrollment
  - Adult
  - Child

Overview

- Core standardized assessments (CSAs)
- interRAI Manual ebooks
  - Available online for purchase by provider
- *interRAI Manual*
  - [Part I]: Assessment process
  - [Part II]: Item-by-item guide

Core Standardized Assessments (CSAs)

- CSAs improve efficiency, consistency and fairness in eligibility determination and assessments for LTSS.
- They must include a uniform process for:
  - Determining eligibility for Medicaid-funded LTSS.
  - Identifying individual support needs.
  - Informing members of their service and support planning (e.g., plans of care).

interRAI Assessments

- Proprietary tool developed by interRAI, an international consortium devoted to improving care for medically complex and disabled persons.
- Several different versions, utilized across multiple waivers.

CSAs (cont.)

Waiver/Serivce Title	Age	DHS Designated Assessment Tool
Children's Mental Health	0-3	CM Comprehensive Assessment
	4-18	interRAI-Child and Youth Mental Health (ChYMH)
	12-18	interRAI-Adolescent Supplement (in addition to ChYMH)
Habilitation Services	16-18	interRAI-Child and Youth Mental Health (ChYMH)
	19+	interRAI-Community Mental Health (CMH)

interRAI Adolescent Supplement

For the Children's Mental Health Waiver, the interRAI Adolescent Supplement is required to be used in addition to the ChYMH assessment for individuals age 12-18.

Of note however, it is the intent of the publishers that the *interRAI Adolescent Supplement* should be completed for youth [12 years of age and older as well as children 11 years of age and younger] whose behavior reflects that which is common in adolescence.

Assessment administration

- Assessments are designed to be used by mental health professionals (i.e., nurses and case managers).
- Provider agencies are responsible for implementing a quality assurance system to ensure the accuracy of assessments.
  - For more information, see page [2 of both] manuals.

interRAI CMH:	*interRAI ChYMH*
Materials: • [10-page] assessment • Manual	**Materials:** • [12-page] assessment • Manual

Assessment administration

Quality assurance system
(page 2 of both manuals)

- The assessment is designed for use by mental health professionals such as nurses, social workers, case managers, psychiatrists, psychologists, family physicians, and recreational and occupational therapists. With appropriate training, however, individuals without a clinical background can generally perform an accurate assessment. While there are no requirements regarding who performs the assessment, the provider agency is responsible for implementing a quality assurance system to ensure the accuracy of assessments.
- The assessment consists of items and definitions. It should be used as a guide to structure the clinical assessment.
- The assessment process requires communication with the young person and the primary support individual (parent, guardian, or other caregiver), observation of the young person, communication with other members of the clinical team, and review of medical records and other available documents. Where

Obtaining the assessment tool

Both Amerigroup and Iowa Total Care

- Providers to receive license to print
- Password encrypted.

interRAI Manual — Part I: Assessment process

The assessment process includes:

- Observing the member.
- Communicating with clinical team members.
- Communicating with members and primary support partners (if available).
- Reviewing medical records and available documents.
  - When possible, the member should be the primary source of information.

interRAI Manual — Part I: Assessment process (cont.)

About the assessment:

- The assessment form is a standardized tool.
- Items flow in a reasonable sequence.
- The form should add supplemental information to the overall assessment process as judged necessary:
  - Social history
  - Psychological evaluation

interRAI Manual — Part I: Assessment process (cont.)

About the assessment:

- A standard [three-day] observation period should be used for the assessment unless specified on a particular question.
- All questions should be answered; no items should be left blank.
- For scales as well as status and outcome measures, visit [http://www.interrai.org/index.php?id=106].
- Assessments should be completed annually or when there is a significant change in the member's status.
- Assessment results are valid for [one year].
- Assessments should be signed and dated by the member (or member's guardian if applicable) to indicate the member was part of the assessment process.

interRAI Manual — Part II: Item-by-item guide

Part II of the *interRAI Manual* presents the following types of information:

- **Intent** — reason for including the item in the assessment
- **Definition** — explanation of key terms
- **Process** — sources of information and methods for determining the correct response for an item
- **Coding** — proper method of recording the response for each item and explanations of individual response options

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interRAI Manual — Part II: Item-by-item guide (cont.)

- The slides that follow provide highlights from the assessment user manuals.
  - Note, this presentation does not take the place of reading/utilizing the user manual(s).
  - For full details, please refer to the user manual(s).
- Except where noted, information provided is the same for both assessments.

CMH sections

A.	*Identification information*	*K.*	*Stress and trauma*
B.	*Intake and initial history*	*L.*	*Medications*
C.	*Mental status*	*M.*	*Service utilization and treatments*
D.	*Substance use or excessive behavior*	*N.*	*Nutritional status*
E.	*Harm to self or others*	*O.*	*Social relations*
F.	*Behavior*	*P.*	*Employment, education and finances*
G.	*Cognition*	*Q.*	*Environmental assessments*
H.	*Functional status*	*R.*	*Diagnostic information*
I.	*Communication and vision*	*S.*	*Discharge*
J.	*Health conditions*		

ChYMH sections

The *ChYMH* includes the sections identified on the previous slide as well as:

- Strengths and resilience.
- Cognition and executive functioning.
- Hearing, vision and motor.

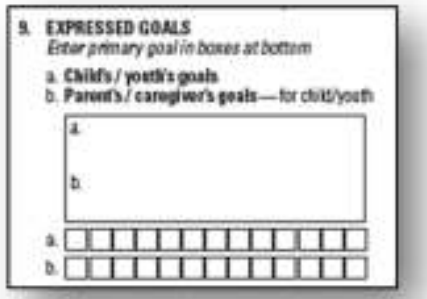
Section [A]: Identification information

Process and coding:	• Health care number = state ID number • Case record number = [0] • Province or territory = [0] • Current payment sources = [0]

Section [A]: Identification information (cont.)

Process and coding:	For the *Expressed Goals of Care* field: • Use the large box to record the person's verbatim response: – *Improve my functioning, better health, improve my relationships* – If the person is unable to articulate their goals, enter *none*. • Use the single line of boxes underneath to record the person's primary goal of care.

CMH



ChYMH

Section [B]: Intake and initial history

For CMH, complete *Section [B]* at admission/[first] assessment only.	
Intent:	Collect the member's: • Origin. • Primary language — see manual appendix for codes. • Parental and developmental history (for *ChYMH* only).

Section [C]: Mental status

Intent:	An assessment of the member's mental status provides information about his/her qualify of life, responsiveness and adherence to treatment regimens, and resource requirements.

Section [C]: Mental status (cont.)

Process and coding:	• Provide a summary of the indicators observed in the last [three days] including information about the severity of the member's condition. • Mental state indicators may be expressed verbally through direct statements. • Nonverbal indicators and behaviors can be monitored by observing the member during usual daily routines. • Be aware of cultural differences in how these indicators may be manifested.

Section [C]: Mental status (cont.)

Process and coding (cont.):	• For the *Degree of insight* field (CMH only): – Ask the member about his/her view of the present situation. – Determine if the member recognizes that a problem even exists. • For the *Self-reported mood* field (CMH only): – Use only the member's responses to rate the questions.

Section [D]: Substance use or excessive behavior — CMH

Process and coding:	• Ask the member if he/she drinks alcoholic beverages. – If the member answers yes, ask *What is the highest number of alcoholic beverages you consumed during a single episode in the last 14 days?* • Consultation with family or friends may be necessary. • If there is a discrepancy in the reported amount, use clinical judgement to code this item.

Section [D]: Substance use or excessive behavior — CMH (cont.)

Process and coding (cont.):	• Discussions about substance-related problems can be introduced to the member by conveying how important it is to care planning and treatment. • Information about substance use can cause uneasy feelings for the assessor. – Care must be taken to acknowledge these feelings. – Ask how the member feels about his/her drinking/drug use. – Ask member if others disapprove of his/her use. • If so, determine how this disapproval makes the member feel.

Section [D]: Substance use or excessive behavior — ChYMH

Process and coding:	• When possible, directly ask the member simple and nonjudgmental questions: – *Are there people in your life who drink or get high a lot?* – *Do feel pressured to drink or get high?* • Be sure to discuss any problems with video gaming and internet use in the last [90] days.

Section [E]: Harm to self or others

Intent:	For those who are at risk of engaging in self-harm and/or hurting others, it is critical that care planning immediately focus on interventions that address safety and prevention.
Process and coding:	Information for items in this section may be obtained through family members, therapists, self-reporting, clinical records, arrest records and other judicial proceeding records.

Section [F]: Behavior

Intent:	This section is meant to capture an objective view of member behavior symptoms — not the intent of member actions.
Process and coding:	• Observe the member — taking note of how he/she reacts to others. – For *ChYMH*, behaviors should only be noted if observed in the last [three days] or are known to be a current issue. • While the member is not in the room, ask those who provide direct care or support if they can identify the member's behavior throughout the last [three days and nights].

Section [G]: Cognition

Intent:	This section is meant to determine if the member is actively making decisions on how to manage tasks — NOT if others believe the member is capable of making those decisions.
Process and coding:	Cognitive skills for daily decision-making requires you to: • Identify the lack of a member's ability or opportunity to participate in decision-making. • Determine if others simply don't agree with the member's decision. – A member's active involvement in making decisions is not considered an impairment.

Section [G]: Cognition (cont.)

Process and coding (cont.):	• Regarding the assessment of the *Memory/recall ability* field, see page [61] of the *CMH* manual and page [67] of the *ChYMH* manual for examples of a structured approach to assess short-term memory. • For evaluation of the *Periodic disordered thinking or awareness* field (for *CMH*): – Frequent delirium (an acute confused state) means the condition is caused by a treatable illness. – Code for the member's behavior in the last [three days].

Section [H]: Functional status

Intent:	Mental illness can compromise a member's ability to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs).
Process and coding:	Question the member directly about his/her level of involvement in IADLs around the home or in the community in the last three days and his/her capacity to perform these activities. • For *ChYMH*, evaluate involvement in the last [seven] days.

Section [H]: Functional status (cont.)

Process and coding (cont.):	For the *Physical function improvement potential* field: • If appropriate, ask about the member's goals for the next few months. • Does the member think he/she could be more independent or improve in any area of physical functioning?

Section [H]: Functional status (cont.)

CMH

SECTION H. Functional Status

1. **IADL SELF-PERFORMANCE AND CAPACITY**
Code for PERFORMANCE in routine activities around the home or in the community during the LAST 3 DAYS

Code for CAPACITY based on presumed ability to carry out activity as independently as possible. This will require "speculation" by the assessor.

0 Independent—No help, set-up, or supervision
1 Set-up help only
2 Supervision—Oversight / cueing
3 Limited assistance—Help on some occasions
4 Extensive assistance—Help throughout task, but performs 50% or more of task on own
5 Maximal assistance—Help throughout task, but performs less than 50% of task on own
6 Total dependence—Full performance by others during entire period
8 Activity did no occur—During entire period [DO NOT USE THIS CODE IN SCORING CAPACITY]

Performance Capacity

a. **Meal preparation**—How meals are prepared (e.g., planning meals, assembling ingredients, cooking, setting out food and utensils)

ChYMH

SECTION I. Independence in Daily Activities

1. **IADL SELF-PERFORMANCE AND CAPACITY**
Code for PERFORMANCE in routine activities around the home or in the community during the LAST 7 DAYS

Code for CAPACITY based on presumed ability to carry out activity as independently as possible. This will require "speculation" by the assessor.

0 **Independent**—No help, set-up, or supervision
1 **Set-up help only**
2 **Supervision**—Oversight / cueing
3 **Limited assistance**—Help on some occasions
4 **Extensive assistance**—Help throughout task, but performs 50% or more of task on own
5 **Maximal assistance**—Help throughout task, but performs less than 50% of task on own
6 **Total dependence**—Full performance by others during entire period
8 **Activity did not occur**—During entire period (DO NOT USE THIS CODE IN SCORING CAPACITY)

P – Performance C – Capacity P C

a. **Ordinary housework**—How ordinary work around the house is performed (e.g., chores such as doing dishes, making bed, tidying up

Section [I]: Communication and vision

Intent:	Difficulties in communicating with others can be isolating: • Making it difficult for him/her to provide information about his/her physical or psychological state or condition. • Interfering with his/her understanding of instructions.
Process and coding:	Interact with the member; observe and listen to his/her efforts to communicate with you.

Section [J]: Health conditions

Process and coding:	• Ask the member, *In general, how do you rate the condition of your health?* • Regarding fatigue, ask the member if he/she has felt tired lately. – If fatigue has been absent over the last [three days] but may have been present if the member had engaged in activity, code according to the activity level that would normally have caused the member to become fatigued.

Section [J]: Health conditions (cont.)

Process and coding (cont.):	• There are no objective markers or tests to indicate when someone is having pain or to measure its severity. • Be sure to inquire about extrapyramidal symptoms (side effects commonly seen when administered with a neuroleptic medication [an antipsychotic]).

Section [K]: Stress and trauma

Intent:	This section is used to assess the potential of post-traumatic stress disorder.
Definition:	Life events are objective experiences that will enhance, disrupt or threaten to disrupt a person's current daily routine and impose some degree of readjustment.

Section [K]: Stress and trauma (cont.)

Process and coding:	• If the member acknowledges experiencing one or more negative life events, ask how he/she is dealing with the memories of these events. • The member (or their care supports) may describe intense fear or horror as a result of these experiences.

Section [L]: Medications

Process and coding:	• Document all medications (prescribed, nonprescribed and over-the-counter) the member has taken in the last [three days]. • Record any prescribed medication that may not have been taken in the last [three days] but is a part of the member's regular medication regimen (i.e., [monthly B-12] injections). • Only count medications that were actually taken by the member in the last [three days].

Section [L]: Medications (cont.)

Process and coding (cont.):	Regarding adherence to medication regimen: • Ask the member if he/she missed taking any prescribed medications over the last [three days]. • Ask family members if they administer medication to the member. • Check the member's response with available medication. • Code for adherence during the last [three days].

Section [L]: Medications (cont.)

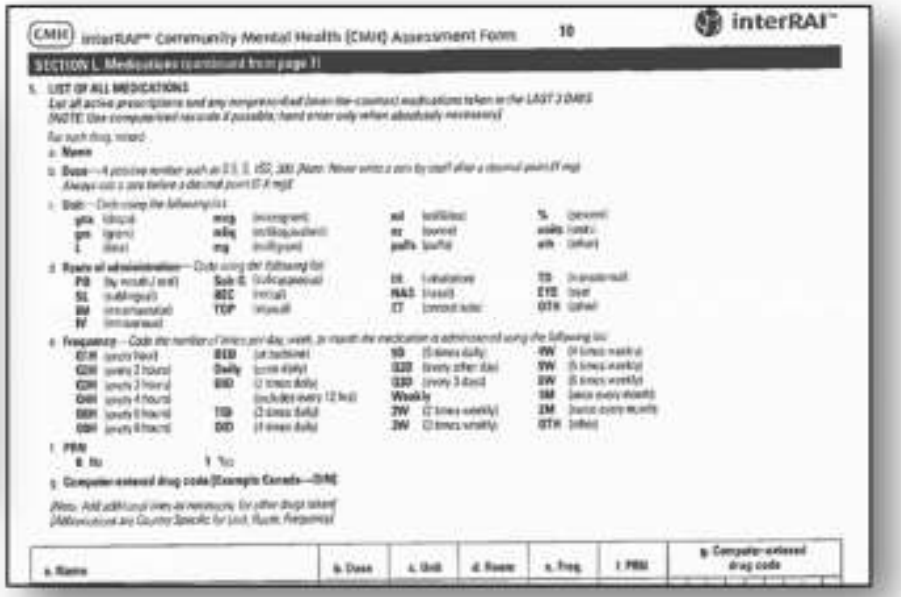
Process and coding (cont.):	Note if the member stopped taking psychotropic medication in the last [90 days] due to side effects. • If the member has experienced side effects in the past, chances are he/she will experience them again. • It is critical to determine if an unwanted side effect is the reason why the member stopped taking the medication (as opposed to general noncompliance, like forgetfulness).

Section [L]: Medications (cont.)

CMH

SECTION L. Medications

1. **LIST OF ALL MEDICATIONS**
   Document medications on last page in space provided
2. **ADHERENT WITH MEDICATIONS PRESCRIBED BY PHYSICIAN** ☐
   - 0 Always adherent
   - 1 Adherent 80% of time or more
   - 2 Adherent less than 80% of time, including failure to purchase prescribed medications
   - 8 No medications prescribed
3. **STOPPED TAKING PSYCHOTROPIC MEDICATION IN LAST 90 DAYS BECAUSE OF SIDE EFFECTS** ☐
   - 0 No, or no psychotropic medications
   - 1 Yes



CMH interRAI™ Community Mental Health (CMH) Assessment Form 10 interRAI™

SECTION L. Medications (continued from page 1)

1. LIST OF ALL MEDICATIONS

Section [M]: Service utilization and treatments

Process and coding:	• See pages 107-112 of the *CMH* manual, and pages 126-128 of the *ChYMH* manual for specific definitions — for example: – Other mental health staff = addiction counselor, rehabilitation counselor or dietitian – Complimentary therapy or treatment = such as aromatherapy, acupuncture or massage • *ChYMH* — Dental exam in last year and immunizations up-to-date

Section [N]: Nutritional status

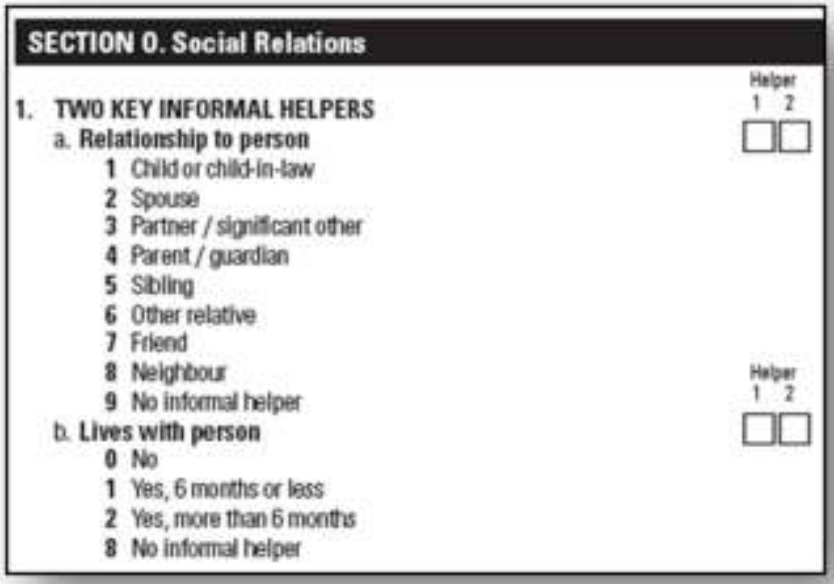
Intent:	A member's nutritional status can be compromised by mental illness as well as somatic issues. This section will identify early detection of nutritional problems and provide baseline information for care planning.
Purpose and coding:	• Be sure to capture the member's height and weight. • For *CMH*, use actual records of weight, if available. – A subjective estimate of weight change can be used if written records are not available.

Section [O]: Social relations — CMH

Intent:	• This section provides an overview of the member's support network and interpersonal relationships. • A strong support network can enhance the member's well-being and his/her ability to live in the community.
Definition:	Activity level means that the member went out of the house or building. • The member went outdoors regardless of how long. • This can include going into the yard, standing on an open porch or walking down the street.

Section [O]: Social relations — CMH (cont.)

Process and coding:	In order to report key informal helpers, code columns one and two. For example: • Helper [1 = 2] for spouse • Helper [2 = 5] for sibling



SECTION O. Social Relations

1. **TWO KEY INFORMAL HELPERS** — Helper 1 2
   a. **Relationship to person**
      1 Child or child-in-law
      2 Spouse
      3 Partner / significant other
      4 Parent / guardian
      5 Sibling
      6 Other relative
      7 Friend
      8 Neighbour
      9 No informal helper — Helper 1 2
   b. **Lives with person**
      0 No
      1 Yes, 6 months or less
      2 Yes, more than 6 months
      8 No informal helper

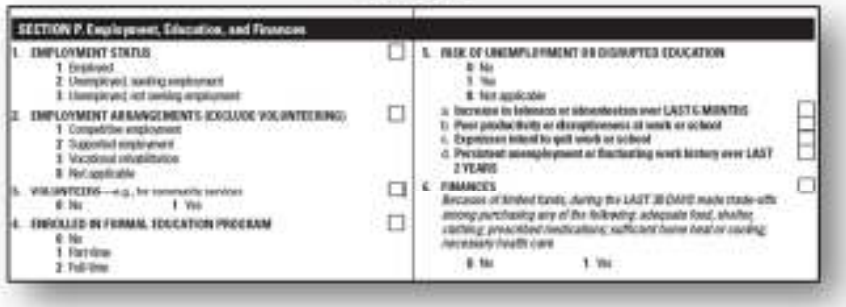
Section [O]: Social relations — CMH (cont.)

Purpose and coding:	Explore to see if the member believes his/her relationship with immediate family is disturbed or dysfunctional. • Interview the member and family separately. • Ask about communication with [one] another (do they talk about ordinary daily events, household chores, the children, etc.). • Identify to what extent the member feels family relationships are based on mutual respect, affection and caring.

Section [P]: Employment, education and finances

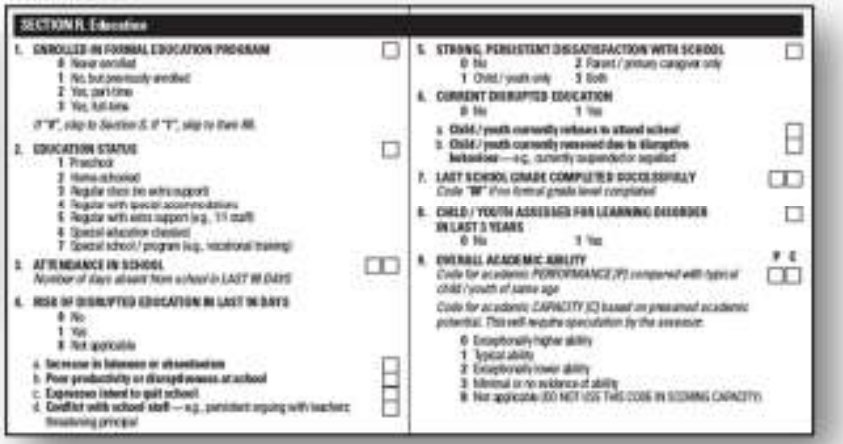
Intent:	A member's well-being, self-esteem and ability to function effectively may be influenced by having meaningful employment, being involved in education, having an adequate income and volunteering.

CMH


SECTION P. Employment, Education, and Finances

1. EMPLOYMENT STATUS
2. EMPLOYMENT ARRANGEMENTS (EXCLUDE VOLUNTEERING)
3. VOLUNTEERS—e.g., for community services
4. ENROLLED IN FORMAL EDUCATION PROGRAM
5. RISK OF UNEMPLOYMENT OR DISRUPTED EDUCATION
6. FINANCES

ChYMH


SECTION R. Education

1. ENROLLED IN FORMAL EDUCATION PROGRAM
2. EDUCATION STATUS
3. ATTENDANCE IN SCHOOL
4. RISK OF DISRUPTED EDUCATION IN LAST 90 DAYS
5. STRONG, PERSISTENT DISSATISFACTION WITH SCHOOL
6. CURRENT DISRUPTED EDUCATION
7. LAST SCHOOL GRADE COMPLETED SUCCESSFULLY
8. CHILD / YOUTH ASSESSED FOR LEARNING DISORDER IN LAST 3 YEARS
9. OVERALL ACADEMIC ABILITY

Section [Q]: Environmental assessment

CMH and ChYMH

SECTION Q. Environmental Assessment

1. **HOME ENVIRONMENT**
   Code for any of following that make home environment hazardous or uninhabitable (if temporarily in institution, base assessment on home visit)
   - 0 No
   - 1 Yes
   - 8 Unknown, home not visited or no information

   a. **Disrepair of the home**—e.g., hazardous clutter; inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridors; holes in floor; leaking pipes ☐

   b. **Squalid condition**—e.g., extremely dirty, infestation by rats or bugs ☐

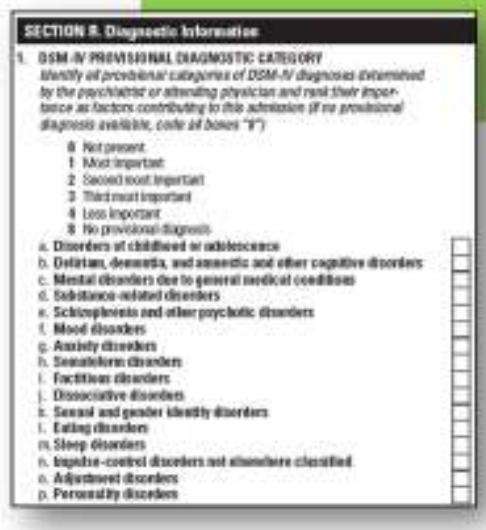
   c. **Inadequate heating or cooling**—e.g., too hot in summer, too cold in winter ☐

   d. **Lack of personal safety**—e.g., fear of violence, safety problem in going to mailbox or visiting neighbours, heavy traffic in street ☐

   e. **Limited access to home or rooms in home**—e.g., difficulty entering or leaving home, unable to climb stairs, difficulty manoeuvring within rooms, no railings although needed ☐

Section [R]: Diagnostic information

Intent:	For the DSM-IV provisional diagnostic category, the intent is to provide up to [four] provisional diagnoses (or actual diagnoses if available at the time of the assessment) as determined by a psychiatrist or attending physician/mental health therapist and rank their importance as factors contributing to this admission.



SECTION R. Diagnostic Information

1. DSM-IV PROVISIONAL DIAGNOSTIC CATEGORY

Identify all provisional categories of DSM-IV diagnoses determined by the psychiatrist or attending physician and rank their importance as factors contributing to this admission (if no provisional diagnosis available, code all boxes "9")

0 Not present
1 Most important
2 Second most important
3 Third most important
4 Less important
9 No provisional diagnosis

a. Disorders of childhood or adolescence
b. Delirium, dementia, and amnestic and other cognitive disorders
c. Mental disorders due to general medical conditions
d. Substance-related disorders
e. Schizophrenia and other psychotic disorders
f. Mood disorders
g. Anxiety disorders
h. Somatoform disorders
i. Factitious disorders
j. Dissociative disorders
k. Sexual and gender identity disorders
l. Eating disorders
m. Sleep disorders
n. Impulse-control disorders not elsewhere classified
o. Adjustment disorders
p. Personality disorders

Section [R]: Diagnostic information (cont.)

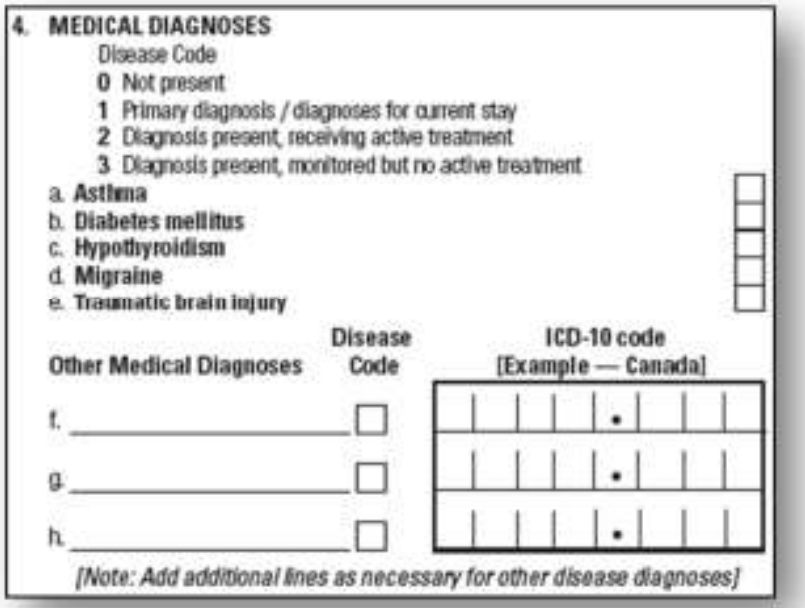
Definitions:	• For *CMH*, intellectual disability information can be found on page [153] of the *CMH User's Manual*. • For the *Medical diagnoses* field: – Primary diagnosis(es) for current stay = the main diagnosis(es) used to support and justify services. – Diagnosis present, receiving active treatment = treatment including medications, therapy or other skilled interventions such as wound care or suctioning. – Diagnosis present, monitored but no active treatment = diagnosis is being monitored (e.g., laboratory tests or vital signs) but active treatment is not being provided.

Section [R]: Diagnostic information (cont.)

Process and coding:	• Diagnostic information should be coded using ICD-10. • For the psychiatric diagnoses field, document the specific psychiatric diagnoses as determined by the psychiatrist/mental health therapist. – This must be completed on discharge but can be completed earlier if a psychiatric diagnosis has already been determined. • Diagnosis(es) must be documented in the member's health record.

Section [R]: Diagnostic information (cont.)

CMH



4. **MEDICAL DIAGNOSES**

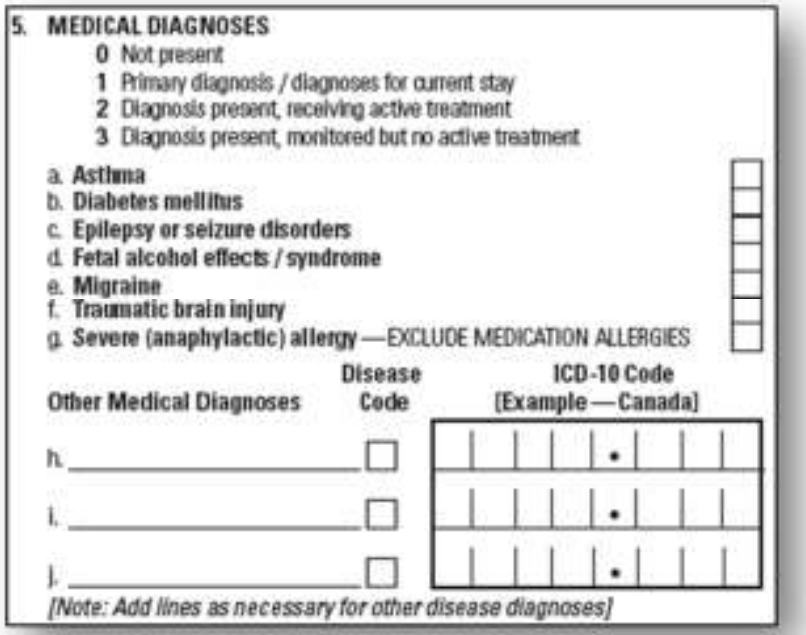
Disease Code
0 Not present
1 Primary diagnosis / diagnoses for current stay
2 Diagnosis present, receiving active treatment
3 Diagnosis present, monitored but no active treatment

a. **Asthma**
b. **Diabetes mellitus**
c. **Hypothyroidism**
d. **Migraine**
e. **Traumatic brain injury**

Other Medical Diagnoses	Disease Code	ICD-10 code [Example — Canada]
f. _____	☐	☐☐☐☐.☐☐☐
g. _____	☐	☐☐☐☐.☐☐☐
h. _____	☐	☐☐☐☐.☐☐☐

[Note: Add additional lines as necessary for other disease diagnoses]

ChYMH



5. **MEDICAL DIAGNOSES**

0 Not present
1 Primary diagnosis / diagnoses for current stay
2 Diagnosis present, receiving active treatment
3 Diagnosis present, monitored but no active treatment

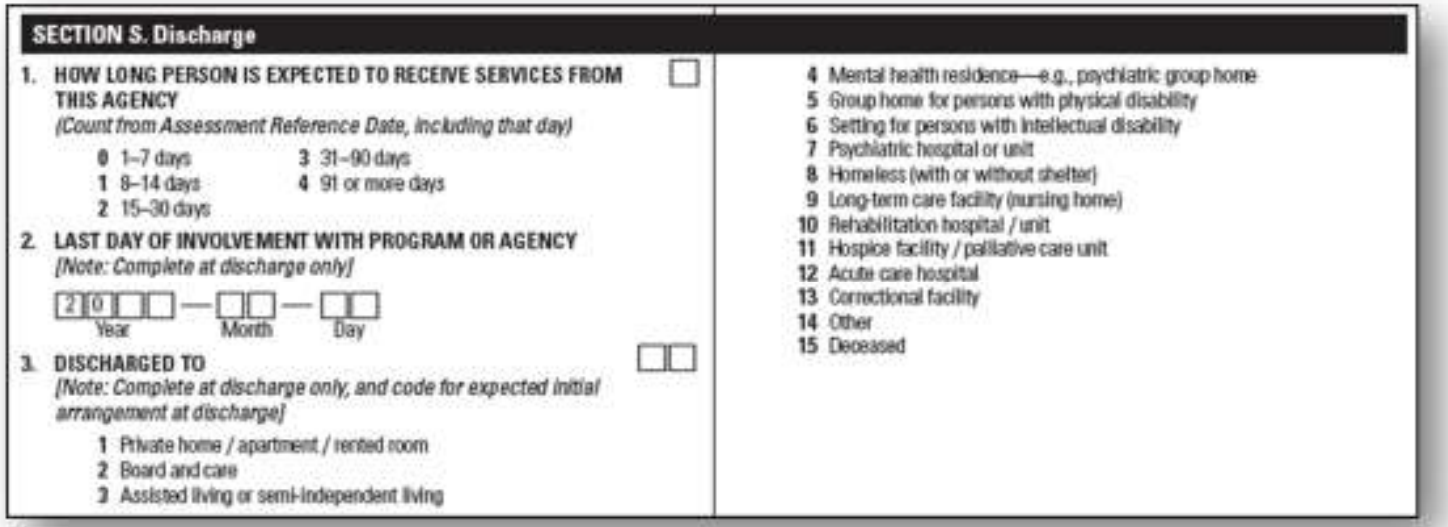
a. **Asthma**
b. **Diabetes mellitus**
c. **Epilepsy or seizure disorders**
d. **Fetal alcohol effects / syndrome**
e. **Migraine**
f. **Traumatic brain injury**
g. **Severe (anaphylactic) allergy** —EXCLUDE MEDICATION ALLERGIES

Other Medical Diagnoses	Disease Code	ICD-10 Code [Example — Canada]
h. _____	☐	☐☐☐☐.☐☐☐
i. _____	☐	☐☐☐☐.☐☐☐
j. _____	☐	☐☐☐☐.☐☐☐

[Note: Add lines as necessary for other disease diagnoses]

Section [S]: Discharge

Process and coding:	Questions [2] and [3] are specific to discharge from the program (*Habilitation* or *Children's Mental Health Waiver*).



SECTION S. Discharge

1. **HOW LONG PERSON IS EXPECTED TO RECEIVE SERVICES FROM THIS AGENCY** ☐
   (Count from Assessment Reference Date, including that day)
   - 0 1–7 days
   - 1 8–14 days
   - 2 15–30 days
   - 3 31–90 days
   - 4 91 or more days
2. **LAST DAY OF INVOLVEMENT WITH PROGRAM OR AGENCY**
   (Note: Complete at discharge only)
   2 0 ☐☐ — ☐☐ — ☐☐
   Year — Month — Day
3. **DISCHARGED TO** ☐☐
   (Note: Complete at discharge only, and code for expected initial arrangement at discharge)
   - 1 Private home / apartment / rented room
   - 2 Board and care
   - 3 Assisted living or semi-independent living
   - 4 Mental health residence—e.g., psychiatric group home
   - 5 Group home for persons with physical disability
   - 6 Setting for persons with intellectual disability
   - 7 Psychiatric hospital or unit
   - 8 Homeless (with or without shelter)
   - 9 Long-term care facility (nursing home)
   - 10 Rehabilitation hospital / unit
   - 11 Hospice facility / palliative care unit
   - 12 Acute care hospital
   - 13 Correctional facility
   - 14 Other
   - 15 Deceased

Person-Centered Care Plan- Section 3A

Section 3: Risk Factors and Emergency Plan

3A Risk Factors		
interRAI assessment sections	**Identified risk factors**	**Measures in place to minimize, including back-up plans and strategies when needed**
Mental Health	Click here to enter text.	Click here to enter text.
Substance Use or Excessive Behaviors	Click here to enter text.	Click here to enter text.
Harm to Self and Others	Click here to enter text.	Click here to enter text.
Behavior	Click here to enter text.	Click here to enter text.
Cognition and Executive Functioning	Click here to enter text.	Click here to enter text.
Functional Status- Independent activities of daily living (IADL) and Activities of daily living (ADL)	Click here to enter text.	Click here to enter text.
Communication	Click here to enter text.	Click here to enter text.
Hearing, Vision, and Motor	Click here to enter text.	Click here to enter text.
Health Conditions	Click here to enter text.	Click here to enter text.

Habilitation Assessment Workgroup Update

- Add closer to August

Questions?

Open Discussion

Thank you!